Rehabilitation Plan
March-2002

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Executive Summary

OmniCare Health Plan ("OmniCare") or (“Health Plan”) was placed in a conservator status in 1998 due to fiscal instability. On July 31, 2001 the Ingham County Circuit Court, at the request of the State of Michigan-Office of Finance and Insurance Services (“OFIS”), entered an order of rehabilitation. Pursuant to MCL 500.8114, the court appointed Frank M. Fitzgerald, Commissioner, as the Rehabilitator. Mr. Fitzgerald appointed two Deputy Rehabilitators, Bobby Jones and Beverly Allen, who are responsible for the day-to-day operations of OmniCare. This Rehabilitation Plan is submitted in accordance with MCL 500.8115.

MCL 500.8115 (4) empowers the Rehabilitator to provide corrective measures for current operations and to submit a plan of rehabilitation, where feasible. The following is an excerpt:

> *If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he or she shall prepare a plan to effect those changes. Upon application of the rehabilitator for approval of the plan, and after notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. A plan approved under this section shall be, in the court's judgment, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall implement the plan.*

Since being placed in rehabilitation, OmniCare has been financially stabilized inasmuch as operating results have been positive. For the five-month rehabilitation period in 2001, a surplus of approximately $3 million was generated. For calendar year 2002, it is projected that the organization will generate a surplus of $4.4 million on approximately $179 million in revenue.

Other factors have had a significant impact upon this Rehabilitation Plan submission. The creditor provider community has responded positively to discussions with the Deputy Rehabilitators for continuation of OmniCare. Their support is a result of significant improvements in OmniCare's operations since the rehabilitation status began and the belief that the organization is stabilizing and will continue to operate successfully in the future. The continuation of operations will benefit these creditors by a larger return on their debts than through liquidation of OmniCare.

If OmniCare were liquidated, non-subordinated creditors would receive approximately $.26 on the dollar of debt. Conversely, the proposed rehabilitation proposal provides for the average non-subordinated creditor receiving approximately $.46 on the dollar of debt (on a weighted average basis). The proposed creditor stratification plan takes several factors into consideration when establishing the levels of reimbursement: previous levels of reimbursement, contractual rates of reimbursement, ability to absorb write-offs, etc.

Based on these and many other compelling factors set forth in the discussion on rehabilitation, OmniCare is an appropriate candidate for a turnaround. Therefore, in accordance with the requirements of MCL 500.8115 (4), this Rehabilitation Plan is being submitted to the Ingham County Circuit Court for its consideration.

Recommendations:

- Approve the Rehabilitation Plan and debt restructuring as submitted.
- Stipulate that the provider reimbursement rate for services to Medicaid enrollees be established at the Medicaid rates as periodically modified by the State of Michigan.
- Stipulate that the injunctions in the original rehabilitation court order remain in effect for the duration of the rehabilitation status.

OmniCare History and Current Issues

History

In May of 1971, a group of physicians, consumers and businessmen each contributed $400 and their time and effort to establish a non-profit corporation called the Detroit Medical Foundation ("DMF"). One of the major objectives of DMF was to determine through research and planning, the feasibility of developing a health maintenance organization ("HMO") to serve the Metropolitan Detroit area.

Based upon the promising results of the feasibility study, DMF applied for and received a $70,000 grant in early 1973. In June 1973, DMF was awarded a $206,000 development grant by the Department of Health, Education and Welfare ("HEW") to finalize the organizational, marketing, provider capability, and service relationship areas. Since DMF was determined by the Internal Revenue Service to be a 501(c) (3) tax exempt organization (i.e. the corporation's activities were primarily devoted to research and development), which could not operate an HMO, a new organization was created, Michigan HMO Plans, Inc.

Michigan HMO Plans, Inc. prepared a proposal to the Michigan Department of Social Services ("MDSS") requesting a contract to provide comprehensive prepaid health care services to 40,000 Medicaid (Title XIX of the Social Security Act) recipients who lived in Wayne County. After months of negotiation, an agreement was signed in December 1973.

The first Title XIX recipients were enrolled in Michigan HMO Plans, Inc. in February 1974. From that day to the present, the Corporation, through its public relations and marketing departments, has attempted to enhance the enrollees' awareness about the HMO concept and the benefits of being a part of an organized system of health care.

Michigan HMO Plans, Inc. reorganized as a health maintenance organization on December 16, 1975. In addition, the Health Plan filed an application for licensure as a health maintenance organization with the Director of the Department of Public Health. The Director, with the concurrence of the Commissioner of Insurance, issued Michigan HMO Plans, Inc. the first license as a health maintenance organization in Michigan on December 23, 1975. This license authorized the Corporation to issue health maintenance contracts to private employers, employee groups, such as unions, and individuals, as well as Medicare and Medicaid.

The Plan received a favorable determination from the Internal Revenue Service as a tax-exempt 501(c) 4 organization. Under Section 501 (c) 4 of the Internal Revenue Code, an organization that is established primarily for "social welfare purposes" may be granted exemption from federal taxation, except to the extent of paying taxes on "any unrelated business income".

In December 1976, Michigan HMO Plans, Inc. submitted its application for federal qualification to HEW and became Federally qualified April 14, 1978. In February 1979, Michigan HMO Plans, Inc. received permission from the Office of Personnel Management (“OPM”) to enroll Federal employees who are eligible for participation in the Federal Employees Health Benefits Program (“FEHBP”).

In August 1988 Michigan HMO Plans filed the assumed name, OmniCare Health Plan and in September 2000, the name was officially changed to OmniCare Health Plan.

Governance

Prior to the rehabilitation status, OmniCare had a 27 member Board of Trustees with 8 physicians, 9 adult enrollee members and 10 other individuals. This ratio is in compliance with the State of Michigan statutes for Board of Trustee composition for

health maintenance organizations. Attachment B provides a graphic presentation of the Board of Trustee structure. The following represents the Committees of the Board:

- Executive
- Strategic Planning
- By-Law Review
- Personnel and Compensation
- Finance
- Management Review
- Quality Improvement ("QIC")
- Peer Review
- Provider Appeals
- Grievance
- Provider Contracts and Credentials

Current Issues

Personnel

A myriad of factors led to OmniCare's rehabilitation status. In January 2001, there were approximately 205 employees that supported OmniCare's operation. By the end of September 2001, the number of employees had fallen to 140. The loss of staff was a result of the uncertainty of OmniCare's stability due to its weak financial condition.

The exodus of key senior management during the four-year period beginning in 1997 compounded OmniCare's staffing challenges. Almost 90% of the leadership resigned from 1997 through 2000. The inability to attract and retain qualified personnel negatively impacted OmniCare's performance. However, it is important to mention that the individuals currently filling the senior management roles have been dedicated during this difficult and challenging period.

Delivery System

Health care provider participation in the Health Plan's delivery system waned over the last several years. The provider network, which had grown accustomed to OmniCare's routine outreach efforts and provider education, responsive servicing, support, etc., was left unattended. In response, the provider community grew impatient and unresponsive to the Health Plan's needs.

Provider exodus became a serious challenge for OmniCare. This depletion reduced the comprehensive provider options members had come to expect. The Health Plan's limited provider network was only minimally sufficient to meet statutory and industry guidelines for access. The delivery system that once contracted approximately 800 primary care physicians shrank to approximately 500 in less than five (5) years.

Employer Groups

The agent/broker and employer communities reacted to OmniCare's financial problems, delivery system terminations, etc. by limiting their marketing of the Health Plan. As a result of these issues, OmniCare's commercial membership fell from a high of approximately 50,000 members in 1997 to approximately 23,000 in January 2002.

During 2001, major commercial accounts were lost due to OmniCare's reported poor quality outcomes, perceived insolvency, and poor servicing levels. These accounts include General Motors, Detroit Edison and American Axle, to name a few. Other accounts were lost as well, due to the uncertainty of OmniCare's future.

OmniCarePlus

In 1993 OmniCare developed a point of service ("POS") product, OmniCarePlus, designed to attract market share based on the freedoms peculiar to more traditional coverage, but pricing common to HMOs. The product never had the appeal that management anticipated and never attained the critical mass required to support risk

assumption. Coupled with the difficulty in overall administration, claims processing, systems support, etc., the product lost money.

The OmniCare Plus accounts were responsible for significant financial losses. Once the commercial rates were adjusted to be commensurate with the cost, some employer groups chose to cancel their coverage. Though membership was lost, the rate increases were appropriate to bring OmniCare to industry competitive rates and were necessary and beneficial to OmniCare's financial performance.

Enrollment

OmniCare's enrollment mix has changed significantly over the last five years. A summary of the historical membership is included below.

Membership History

Market	1997	1998	1999	2000	2001
Commercial-HMO	41,294	35,135	29,904	29,220	25,736
Commercial-POS	7,353	7,754	7,401	5,274	3,566
Medicaid	48,510	49,791	40,051	65,948	66,366
Total	97,157	92,680	77,356	100,442	95,668

The significance of this chart is that the dependence upon the Medicaid contract has increased significantly. As indicated above, the commercial membership has declined precipitously over the last five years. The January 2002 open enrollment season continued the trend with further losses of approximately 5,700 commercial members. This reflects an overall 51% decline in the commercial membership from 1997 levels to 2002.

Conversely, Medicaid membership has grown over the same period. In early 2000, OmniCare management petitioned the State of Michigan for conversion of approximately 30,000 Medicaid enrollees from the Detroit Medical Center to OmniCare. This

population with a high severity of illness was converted to OmniCare in May 2000. In the first year, this population experienced a medical loss ratio of 116%, which contributed to the financial losses experienced by the Health Plan. In 1997, Medicaid and commercial membership was evenly distributed with a 50%/50% mix. By 2002, the ratios have shifted to a 74%/26% mix between commercial and Medicaid, respectively.

Quality of Care

OmniCare has generally had competitive quality of care measurements. These quality indicators are based on collected data, the generation of the appropriate reports and information supplied to external regulatory bodies and employer benefit consultants. Due to the departure of the experienced staff, the data reporting activities and the quality of that data diminished significantly. As a result, accurate external reports to accrediting bodies and regulatory agencies were non-existent.

Due to the diminishing quality management systems, OmniCare deteriorated from a ***Commendable*** to ***Provisional*** accreditation status granted by the National Committee on Quality Assurance ("NCQA"). NCQA evaluates and accredits HMOs based on a schematic that includes health-outcomes, member support, financial soundness, etc. This was and continues to be a major problem in that maintenance of an acceptable status by an accrediting body is a requirement of many health care purchasers, including the Michigan Department of Community Health.

Financial Performance

Though OmniCare's financial performance was not properly recorded, it was losing money since 1997. In the last two years, prior to the rehabilitation, OmniCare was losing approximately $1.5 to $2 million dollars per month. Inpatient utilization levels, i.e. days/thousand, one of the more common measures of HMO effectiveness, were high by approximately 20% to 25% at 686 and 325 for the Medicaid and commercial markets, respectively. Several activities in the medical management area were discontinued as a result of the loss of staff. This resulted in an increase in unmanaged medical cost which

is ironic in that no savings were realized in administrative costs since OmniCare was paying a percentage of premium based management fee for administrative services.

OmniCare had several deficiencies relative to its financial performance. Budgets were not prepared for the last several years pursuant to its financial targets. Positions were filled with no formal plan disseminated to management. Due to the number of erroneous and/or duplicate claims and refunds from providers, OmniCare experienced a loss of control over bank accounts and bank reconciliations were not completed.

OmniCare was not aggressively pursuing collections from employer groups. Employer member reconciliations were also significantly behind causing OmniCare to pay claims for members not enrolled. The accounts receivable turnover rate was extremely low and well below acceptable standards. Coupled with the lack of reconciliations, membership was overstated as well. This problem resulted in pharmacy and medical claims being paid for individuals not actually covered. Additionally, due to a lack of controls around the submission of eligibility information to the pharmacy benefits manager ("PBM"), as many as 7,000 members were listed with the PBM who were not covered by OmniCare. As a result, the Health Plan erroneously paid for prescriptions for members that were not covered.

OmniCare had several sources of additional revenue that were not pursued. The Health Plan had moved away from aggressively pursuing coordination of benefits ("COB") and reinsurance reimbursements. Relative to COB, the Health Plan had changed its philosophy from a *pursue and pay* to a *pay and pursue* approach. As a result, edits were turned off in the system to process claims with no sensitivity to the actual liability, COB savings were not tracked and potential savings were not realized. The reinsurance recovery process was non-existent. It is likely that these monies cannot be recovered due to a lack of tracking and timely notification.

Among OmniCare's most debilitating deficiencies was its inability to effectively predict its liability for medical costs. At the end of 2000, OmniCare's financial records reflected a negative equity of approximately $8.0 million dollars. It should be mentioned that the auditors, KPMG, could not audit the records and indicated such in the audit opinion. Since that time, the negative equity increased significantly to approximately $57.2 million as of the Rehabilitation Order of July 31, 2001. This deterioration was primarily a result of the medical cost incurred but not reported ("IBNR") having been significantly understated and included adjustments related to prior years as far back as 1999.

Claims Processing

Payment of claims was a major problem for OmniCare; inventories were extremely high. As a result, management took an aggressive action of requiring all employees to process claims without necessary system edits, which were removed and /or bypassed. Though this clearly and significantly reduced the claims inventory, it also resulted in a high error rate as well as several duplicate payments. As noted in the financial statements for the year ending December 31, 2000, approximately $4.0 million dollars were reflected in the financials as duplicates to be recovered.

To improve claims processing efficiency, an optical character recognition system was implemented in May 2000. However, the proper acceptance testing did not occur resulting in recurrent errors. Corrections have been instituted since rehabilitation to rectify many of these problems with additional improvements still underway. For example, the Health Plan is currently testing and will soon be implementing electronic data interchange ("EDI") processing for UB 92 and HCFA 1500 forms for hospital and physician claims, respectively.

Information Systems

Currently OmniCare is utilizing an early version of the CSC-Comtec software that was installed in 1982. Though this product was state of the art at that time, it does not have the functionality necessary in today's environment. It is operational as a result of

layering the Primos© operating system on a Unix emulator to run on Sun© equipment. Claim modifiers were not available, but were added in a limited capacity for Medicaid only claims. There is no claim bundling software that interfaces with the package. Consequently, significant savings have not been realized.

Detroit Medical Center Proposed Acquisition

In early 2001, OmniCare entered into acquisition discussions with the Detroit Medical Center ("DMC"). During the course of DMC's due diligence process, OmniCare began making decisions as if the sale were final. Positions were left vacant and normal maintenance activities were not completed. This inaction prevailed for the first six (6) months of 2001. The DMC chose not to continue with the purchase when they discovered that the Health Plan's medical liabilities were significantly understated. As a result, OmniCare found itself with severe financial problems and operational dysfunction and the only alternative was for the State of Michigan to place it in a rehabilitation status.

Post Rehabilitation Order Plan Improvements/Accomplishments

OmniCare's turnaround continues to be favorable. In the last seven months, the Health Plan's capacity to meet established standards, increase financial stability and improve operational, medical and quality metrics have been demonstrated. These short-term successes demonstrate OmniCare's viability. The current trends lend themselves to a continued positive outlook for OmniCare's partners: employers, enrollees, contractors, providers, employees and the community-at-large.

The following synopsis highlights some important changes and successful outcomes during the rehabilitation period:

- IT capacity has been expanded allowing the capture and reporting of key data, a critical issue for health plans. Since August 2001, OmniCare has submitted over 2.0 million records to the State of Michigan-Dept. of Community Health. This

was a major deficiency since the State's data warehouse is the source for many quality measures. OmniCare has improved its claims processing, standardized payment schedules to the provider community, completed several modifications to its computer system, added additional programming staff and implemented improvements to the communications functionality. All of these activities have added to the efficiency and confidence levels of internal and external clients.

- Claims are being turned around faster and more efficiently than in the past. OmniCare has targeted several operational activities to improve the quality and efficiency of the claims processing functions. Currently, approximately 85% of provider payments are being processed in less than 30 days for clean claims.

- Staffing in the Medical Management Department has tripled. The additional staff has bolstered utilization management and service coordination. OmniCare has implemented several quality programs. Furthermore, OmniCare has been more aggressive in the management of care on a concurrent basis. These improvements have already impacted health care delivery and savings.

- An agreement to expand access to medical professionals after hours has been negotiated with a third party, improving access for OmniCare enrollees.

- Customer Care staffing has also been expanded to improve performance and service levels. Call abandonment rates have been consistently decreasing since August 2001. OmniCare is now reporting single digit abandonment rates.

- Prior to the Rehabilitation Order, the Health Plan had a loss run rate of approximately $1.5-$2 million dollars per month. The confluence of more effective management of costs and improvements to operational efficiencies has resulted in positive financial performance. OmniCare is projecting this positive

financial trend to continue; the 2002 budget reflects a surplus approximating 2% of total revenue.

- OmniCare has reestablished the COB activity as a corporate goal and as a significant enrichment to OmniCare's financial plan. The Health Plan has converted from a pay-and-pursue to a pursue-and-pay approach.

- A Compliance Department has been re-introduced to ensure that the Health Plan develops and maintains a viable compliance program, including oversight of state and federal contracts, HIPAA, etc.

- Recently, the Department of Community Health, Medical services Division, conducted a routine site visit audit. The purpose of these audits is to evaluate health plans' compliance with contractual and regulatory standards related to the Medicaid contract. The review also includes an assessment of general health plan operational practices. OmniCare garnered a passing grade on more than three quarters of the criteria. While this report does not constitute an endorsement of the Health Plan, it is certainly indicative of OmniCare's capacity to meet external review requirements. It also supports the premises reported in the preceding passages that the infrastructure is stabilizing following the execution of the Rehabilitation Order.

Rehabilitation Plan

Governance And Management

- **Governance**

OmniCare is currently organized as a nonprofit membership corporation with the members defined as all-adult enrollee members. In 1997, a process began to stratify the members into classes, with voting and nonvoting members. This was initiated since any

major corporate change or amendment to the articles required the vote of the membership, which at that time, was approximately 100,000 members. No quorum could be convened or a majority of votes received because the numbers were too large and the costs too great. The governance structure of OmniCare is constrained by the large size of its board and the inability to obtain meaningful votes of the membership on corporate issues, such as amendments of articles or bylaws, plans of merger or dissolution, etc. It is recommended that OmniCare be reorganized as a nonprofit directorship corporation during the rehabilitation period, then ultimately, converted to a for profit stock corporation.

NCQA has very specific standards on Board composition. NCQA also requires that the Health Plan Medical Director participate as an active member of the Board of Trustees. The Ingham County Circuit Court upon placing OmniCare in a rehabilitation status suspended the existing Board and gave complete Board authority to the Rehabilitator, Commissioner of OFIS, State of Michigan, Frank M. Fitzgerald. In light of these NCQA requirements and the actions of the Court, four (4) members were seated and granted limited authority by the Commissioner to solely provide oversight of the quality of care related factors only for purposes of meeting quality requirements and accreditation standards. Therefore, the current OmniCare Board is as follows:

OmniCare Board of Trustees

Participant	Position
Frank Fitzgerald	Chairman
Bruce DeSchere, MD	Board Member
Tej Mattoo, MD	Board Member
Herman Gray, MD	Board Member
Barbara Nabrit-Stephens, MD	OmniCare Medical Director, Board Member

A downsized Board is being proposed post rehabilitation. The total will be 9 and the composition will be as follows:

Proposed Board of Trustees-Post Rehabilitation

Type	Quantity
Participating Physicians	2
Medical Director-OmniCare	1
Adult Enrollees	3
Management Member (OmniCare-CEO)	1
Other Community Members	2
Total	**9**

The restructured Board positions will be filled upon approval being granted by the Commissioner and the Ingham County Circuit Court. Until that time, the current Board will remain seated. The Commissioner will have total authority with the medical management and other quality of care decisions delegated to the current Board of Trustee participants.

Consistent with the requirements of NCQA, the existing Committees will remain intact and will be regulated in accordance with the existing By-Laws. Attachment A represents the Committees and their relationship to the Board of Trustees.

The Finance, Compliance and Audit Committee will have responsibility for the fiscal affairs of the company and compliance activities related to HIPAA implementation, governmental contracts and corporate insurance. In light of the numerous operational activities, an audit component has been added to focus on internal controls, policies and procedures.

The Quality Improvement Committee ("QIC") is the quality of care arm of the Board of Trustees. Its establishment, operation and existence are accreditation requirements. The meeting frequency and composition are established in the corporate By-Laws.

The QIC has five sub-committees: Pharmacy, Peer Review, Utilization Review, Confidentiality and the Mental Health Committee. These committees have responsibility for quality, policy and regulatory oversight for their respective areas in the functions of OmniCare. The meeting frequencies and composition are established by the corporate By-Laws.

The Credentials and Provider Contracts Committee oversees the contracting process for provider participation in the Health Plan. These providers have to be recredentialed every 3 years to meet regulatory and NCQA standards. Assurance of complying with State regulatory requirements also resides with this body in that there are very specific requirements for the provider contracting process. Though the Committee reports to the Board, it shares its findings with the QIC since its decisions could have an impact on quality decisions and policies.

The Grievance & Provider Appeals Committee represents one of the steps for relief regarding complaints against the Health Plan by members and providers. The resolution of grievances and complaints is a tightly regulated activity. Standards exist for the management of grievances at the State of Michigan-Office of Financial and Insurance Services, State of Michigan-Department of Community Health, NCQA and the Federal Employees Health Benefit Plan ("FEHBP"). As a result, this Committee reports directly to the Board, but shares its reports with the QIC.

The Strategic Planning Committee is responsible for developing and overseeing the competitive strategy for the Health Plan. The Personnel and Compensation Committee has responsibility to provide general oversight of salaries, grade levels and other policies as they relate to staff.

- **Management**

OmniCare's management agreement with United American Healthcare Corporation ("UAHC") is a twenty-five year agreement commencing in 1985 and was based on a percentage of revenue. In exchange for the percentage, UAHC was responsible for all administrative cost, i.e. personnel and related cost, lease space, systems, advertising, etc. as it related to managing OmniCare. The original agreement stated that termination notice effective December 31 of that year, must be provided in June of 1990, 1995, 2000, 2005, or 2010. Therefore the next opportunity to terminate would have been June 2005.

The original agreement stipulated a 17% of total operating revenues fee, which was reduced to 14% in 1998. The management agreement was continued during rehabilitation to allow the Commissioner and Deputies to focus on the rehabilitation of OmniCare. Subsequent to the Rehabilitation Order, the management agreement with UAHC was renegotiated. The amended agreement is a cost-plus arrangement that averages approximately 8% of OmniCare's revenue. The Commissioner and Deputy Rehabilitators have defined what constitutes cost; furthermore, the agreement allows for expenses to be audited ensuring that they are appropriate and in accordance with the amended agreement.

The amended agreement allows termination, *with or without cause,* with ninety (90) days prior notice. Tentative plans call for the management agreement to be terminated upon approval of the Rehabilitation Plan. The actual dates will be determined as a result of having alternate lease space, the IT decision, staffing issues, office equipment/computer issues, etc.

- **Tax Status**

OmniCare, like any other non-profit, is challenged in raising capital. A critical component of OmniCare's proposal to resolve its creditor liabilities relates to converting some of that debt to equity. In consideration of the capital needs and the desire to convert a portion of the debt to equity, this Rehabilitation Plan proposes that OmniCare be converted to a for-profit entity.

HMOs operating, as for-profits are not foreign to Michigan. The following chart represents a tally of the number of for profits and non-profits serving the residents of Michigan

Profit versus Non-Profit HMOs in Michigan[1]

Market	Non Profit		For Profit[2]	
	#	Membership	#	Membership
Medicaid	13	470,629	6	194,875
Commercial	13	1,957,566	4	167,452

- **Staffing and Organizational Structure**

It is anticipated that a fully functional organization will require approximately 225 employees. In rehabilitation status, it is recommended that one of the Deputy Rehabilitators act in the role of the CEO. The other Deputy Rehabilitator will act as the CFO/COO. However, both positions will continue to report to the Commissioner, in accordance with the Ingham County Circuit Court order as it relates to the rehabilitation process. The remaining management and staff positions will resemble the more traditional HMO structure. This structure will remain intact until such time as it is

[1] Source: http://www.cis.state.mi.us/ofis/pubs/lists/hmo_enrl.asp
[2] Includes SelectCare-Sold in 2001

changed by the Commissioner or by the Ingham County Circuit Court. The proposed organizational chart is available as Attachment C. Attachment D provides the bios of the management staff.

Delivery System

- **Service Area**

OmniCare is licensed and approved to service members in Wayne and Oakland Counties for its Medicaid contract. The commercial service area includes Wayne, Oakland, Macomb, Monroe and Washtenaw counties. Due to expansion cost, there are no HMO service area expansion plans at this time. OmniCare is in the process of transitioning out of Oakland County for its Medicaid population.

Based on the financial assessment of cost and the limitations of the delivery system, OmniCare has provided tentative notification to the State of Michigan, Community Health Department, that it is exiting Oakland County. This decision, if implemented, will result in a reduction of approximately 4,000 members. This decision encourages greater focus on OmniCare's core Medicaid delivery system, located in Wayne County.

Relative to the commercial business, OmniCare will be phasing out of Monroe County. Since OmniCare's inception, this county has been a challenge because the providers are resistant to HMO participation. Previous agreements have always been based on a modified capitation/fee for service in part because of the reluctance of physicians to be capitated.

Monroe County has one hospital, Mercy Memorial. Due to the proximity of Monroe County to Toledo, Ohio, an HMO must contract with Toledo hospitals to effectively serve this population. Considering the number of potential enrollees, it becomes cost

prohibitive to maintain a delivery system to service so few members on a fee for service basis.

Its been determined that, Wayne, Oakland and Macomb Counties have sufficient opportunities for growth in the near term. In addition, expansion outside of the immediate service area generally requires the assumption of a greater amount of risk than OmniCare can effectively undertake.

- **Health Care Financing Model**

OmniCare's financing delivery model is a combination of capitation and discounted fee for service. Primary care, lab services and mental health services are capitated for both commercial and Medicaid. Refractive examinations and glasses are capitated for Medicaid only. For selected hospitals, inpatient services are capitated.

Primary care physicians have some limited risk/rewards associated with the referral services they authorize. Maximum risk is defined as 10% of their reimbursement, which is withheld from their monthly capitation payments. Maximum reward is defined as 50% of their withheld funds.

Though the basic framework of the current model will remain intact, certain improvements are required. The capitation rates were developed based on a weighted average of member mix approximately 4 years ago. There has been no update since that time. Consequently, internal medicine receives the same capitation rate as pediatrics, which receives the same rate as obstetrics. New capitation rates will be developed that are based on the utilization rates and cost for the specific age/sex population.

There has been considerable discussion in the industry relative to whether or not obstetrics should be capitated. In addition, legislation has been passed in several states,

Michigan included, that allow members to select an obstetrician as the primary care physician. Accordingly, the model to be implemented will pay for obstetrics on a discounted fee for service basis with OmniCare assuming the cost.

OmniCare is in the process of evaluating proposals from national mental health providers to assume the overall risk and management of its mental health programs. Due to deficiencies, revisions to the current program are required to meet NCQA requirements.

Quality Programs

- **National Committee on Quality Assurance ("NCQA")**

NCQA accredits managed care organizations based on the Plan's ability to collect data and report quality of care and the outcomes. These quality outcomes are the Health Plan's Health Employer Data Information Set ("HEDIS") measures. NCQA standards for accreditation are not limited to medical care; they are also based on member satisfaction levels, medical outreach results, administrative processes, financial status, and controls.

There are several levels of accreditation: ***Provisional, Accredited, Commendable and Exceptional***, in this order. During its 1998 review, OmniCare was awarded a ***Commendable*** NCQA accreditation status. The Health Plan was surveyed again in January 2001. Due to its delegated provider credentialing/administrative deficiencies, financial status, outdated member materials and deteriorating reported quality outcomes, the accreditation process resulted in OmniCare receiving Provisional NCQA accreditation status.

OmniCare is scheduled for a focused re-survey in July-2002. The re-survey will focus on opportunities for improvement identified by NCQA during the prior onsite audit. Preparation has already begun in an attempt to improve the accreditation status to at least an ***Accredited*** level.

OmniCare has developed a work plan and task force to prepare for the review. Once administrative decisions are made at the operational levels, these recommendations must be submitted to the Board of Trustees via the Quality Improvement Committee ("QIC") for ratification. Since there are several tasks that must be submitted, monthly meetings have been scheduled throughout 2002.

Corporate Compliance/HIPAA

OmniCare has developed its 2002 corporate work plan with an emphasis on corporate compliance and implementation of the HIPAA requirements. The oversight of the HIPAA compliance program is the responsibility of the Compliance and Government Programs Department.

A corporate compliance program fosters a business environment that helps ensure awareness, monitoring and adherence to compliance issues. Effective compliance programs provide multiple benefits to health plans, its members, providers and employees. Through proactive administration of such programs, health plans can significantly reduce their exposure to sanctions, encourage delivery of quality care, improve operational control and efficiency, and promote standardization of processes.

As HIPAA guidelines place a primary emphasis on standardization and protection of member information, its concepts are consistent with the goals of OmniCare's revised compliance program. The Compliance Department is managing the institution of HIPAA related training and development, gap analysis, recruitment and utilization of technical advisers, policy management, business associate compliance assessment and preparation for electronic data interchange ("EDI").

The rehabilitation management team has refocused its attention on the execution of the HIPAA regulations. Each department work plan is developed with HIPAA objectives in

mind. The Privacy and Security officers have been identified. The Confidentiality Committee, a sub committee of the QIC, will be reconvened in March 2002 to address confidentiality and a broad array of HIPAA issues, e.g., privacy, document management, consent/authorization policies, etc.

OmniCare will petition the Centers For Medicare and Medicaid Services ("CMS") for the Transactions and Code Standards implementation extension as prescribed in H.R. 3323. As required, OmniCare will file its extension request by the October 2002 deadline. OmniCare will continue to work closely with OFIS, DCH, public institutions, employers and other business associates to successfully comply with the HIPAA administrative simplification, privacy and security regulations.

Marketing Strategy

- **Marketplace**

OmniCare is the tenth (10^{th}) largest HMO in Michigan serving approximately 90,000 enrollees throughout Southeast Michigan. The company has a mixed enrollment of Medicaid (74%) and commercial (26%) enrollees. Contracts are held with a myriad of groups, including small, medium and large employers. OmniCare offers services to major government agencies including the City of Detroit, Federal Government, Wayne County and the State of Michigan. Over 20% of OmniCare groups have been enrolled for more than ten years. The Health Plan also offers a point of service ("POS") product, OmniCare Plus, which includes nearly 1,000 members. This product line has a mix of small, medium and large groups enrolled. OmniCare was among the few health plans offered to Greek Town casino employees under a joint venture with Blue Cross/Blue Shield of Michigan ("BCBS").

OmniCare also supports the State's initiative to provide insurance coverage to the uninsured by participating in the MI-Child program in Oakland and Wayne counties.

There are approximately 26,000 MI-Child eligibles enrolled in insurance plans. Over 85% of the enrollees participate through the BCBS program.

Health care costs have increased over the last three years, requiring insurers and employers to examine multifaceted options to offer quality, cost effective care. Premium increases have been in double digits over the last several years. Increases in the cost and utilization of prescription drugs are the primary impetus for the recent rate hikes. Historically, HMOs tend to do well in adverse economic times. In light of the current state of the economy, it is believed that significant opportunities exist for a solid commercial Plan in this marketplace.

Michigan's health care marketplace is diverse, offering employer groups a virtual cornucopia of purchasing options. As of 1999, there were approximately 657 licensed insurance companies in the state, 43 of which progressively market group health insurance. There are nearly 82 third party administrators ("TPA") registered to administer group health care programs serving self-funded employers. There are over 19 licensed HMOs, over half of which compete in the OmniCare service area.

OmniCare's competitors in Southeast Michigan for both the commercial and Medicaid business are strong and established. Most of the Plans have histories that date back to OmniCare's origins. The largest distribution of Michigan's insured population is with BCBS, through one of its variety of product lines, including indemnity, preferred provider organization ("PPO"), POS, and HMO. The Blues account for over half the covered lives in the State. From the commercial perspective, Blue Care Network, Health Alliance Plan, M CARE and Care Choices are OmniCare's most significant competitors. Their enrollment accounts for more than a million lives. From the Medicaid perspective, there are more competitors, many of which have enrollment of less than twenty thousand members. The Southeast Michigan Medicaid market accounts for 75% of the state's Medicaid qualified health plans ("QHP").

- **Commercial Products**

Marketing of OmniCare's commercial products has been extremely challenging in that the uncertainty associated with the Health Plan's rehabilitation status has caused some employer groups to eliminate OmniCare from their menu of health benefit plan options. The products currently offered by OmniCare are a commercial HMO and a commercial POS product. The Commercial HMO product is a viable product that is critical to the successful rehabilitation of OmniCare. While the membership has declined, many of the core purchasers including the federal government, State of Michigan, City of Detroit, Wayne County, and Daimler-Chrysler have remained committed to OmniCare.

OmniCare's premiums were approximately 15-20% below market, prior to the rehabilitation order. This pricing philosophy was based on the premise that market share could be purchased. A strategy was undertaken immediately following the Rehabilitation Order to increase the rates to cover the costs of providing medical care. It was anticipated that a loss in membership would occur. However, the alternative was to continue to lose money in this sector. Coupled with the losses in the Medicaid and POS sectors, OmniCare had no profitable products. The average per member per month (pmpm) revenue for 2002 is expected to increase by approximately 16% over 2001 levels. This should result in a profitable commercial product in 2002.

Commercial Approved MCO's by County-SE Michigan [3]

Plan	Wayne	Oakland	Macomb	St. Clair	Monroe	Washtenaw
Aetna	X			X	X	
Blue Care Network	X	X	X	X	X	X
Care Choices						X
Health Alliance Plan	X	X	X	X	X	X
M-Care	X	X	X			X
OmniCare	X	X	X		X	X
The Wellness Plan	X	X	X		X	X
Total Health Care	X	X	X			

- **Preferred Provider Organization ("PPO")**

In the last several years, PPOs have experienced excellent growth. In 1998, nationally, 98.3 million individuals were covered by PPOs. In 1999, this number had grown to 106.8 million (8.7% increase).[4] In 1999, there were 67 owned or internally developed PPOs servicing Michigan residents. Though this number appears to be large and could potentially minimize the success of a new entrant, the major competition in this marketplace is PPOM.

The recent alliance with the DMC related to the administration of its PPO product line, DMC CARE is a unique opportunity to expand the OmniCare portfolio to commercial customers. Through OmniCare TPA, DMC CARE will be marketed to an expanded market, seeking self-insured and TPA options. DMC CARE's current enrollment of 27,000 includes Wayne Sate University employees, DMC employees, Wayne State University students and Wayne County retirees. The strength of the DMC program is its

[3] Source: http://www.cis.state.mi.us/ofis/pubs/guides/health/hmocongd/hmo_service_area.asp
[4] Source: SMG Marketing Group Inc. © 2000

strong network through its affiliation with the Wayne State University Medical School and the DMC provider network.

- **Third Party Administrative ("TPA") Services**

MCL 500.3543 allows an HMO, with the Commissioner's approval, to own or invest in a third party administrator. In December-2001, a wholly owned for profit subsidiary was created, OmniCare TPA, Inc. The new company is licensed to perform administrative services for self-funded employers for medical benefits of their employees. The significance of this product is that it will generate a positive financial contribution to OmniCare's operations, maximize OmniCare's system capabilities and accelerate the payback of capital investments. Though this is a separate entity, it will not have a separate staff. Instead, there will be one management team employed by OmniCare TPA, Inc. servicing both the HMO and TPA product lines. Employees will have distinctive and direct product responsibility. This staffing model will reduce duplication and contribute to maximizing corporate resources.

The relationship with the DMC is positive since it takes advantage of the managed care business experience and potential at OmniCare. In addition, OmniCare's COB activities, which have been effective in generating savings, will be made available to the DMC self funded Program. OmniCare's COB department has demonstrated its ability to generate annual savings of 5% to 7% of medical cost. These savings amount to a significant benefit to the DMC and other self funded employers.

- **Medicaid**

The following charts represent the Medicaid populace and the managed care organizations that compete in this arena in OmniCare's service area:

Populace by County-Total and Medicaid HMO/MCO[5]

Region	Total Population	HMO/MCO Membership
Wayne County	2,061,162	267,383
Oakland County	1,194,156	40,564
Macomb County	788,149	29,993
Washtenaw County	322,895	11,593
St. Clair County	164,235	10,431
Monroe County	145,945	6,709

Medicaid Approved MCO's by County-SE Michigan [6]

Plan	Wayne	Oakland	Macomb	St. Clair	Monroe	Washtenaw
Botsford Health Plan	X					
Cape Health Plan	X	X				
Care Choices						X
Community Choice/Mi					X	
Great Lakes Hlth Plan	X	X	X	X		
Healthplan/Mi		X		X	X	
HealthPlus		X				
M-Care	X					X
Midwest Health Plan	X		X			X
Molina Healthcare	X	X	X			
OmniCare	X	X				
The Wellness Plan	X	X	X	X		
Total Health Care	X	X	X			

[5] Source: http://www.mdch.state.mi.us/msa/mdch_msa/1listing.asp and Census 2000
[6] Source: http://www.mdch.state.mi.us/msa/mdch_msa/qhplist.htm#clinton

- **Membership Projections**

Clearly, an aggressive and targeted market plan must be executed in order to improve the Health Plan's market share and to have a significant impact on health growth. OmniCare completed a five (5) year growth plan as part of the process to determine the valuation of the corporation. The following represents the membership targets thru 2006:

Membership Projections

Market	2002	2003	2004	2005	2006
Commercial-HMO[7]	21,527	26,438	29,081	31,990	35,189
Commercial-POS	1,211	0	0	0	0
Medicaid	63,477	63,477	63,477	64,112	64,753
TPA	27,000	27,000	27,000	27,000	27,000
Total	113,125	116,195	119,558	123,102	126,942

The commercial membership projections include conservative growth as operations continue to stabilize. The POS membership ends after 2002 since OmniCare will be phasing out of this product. Medicaid membership is held flat in an attempt to reduce its ratio to total membership. PPO membership is presented to show the total membership under OmniCare through its TPA subsidiary.

Membership Strategies

The organization has great potential to restore its reputation among consumers and business partners. Despite some of the aforementioned market factors, OmniCare has still maintained a core commercial base and continue to attract new Medicaid enrollees. The Health Plan still has a core provider network, especially in Wayne County.

[7] Includes Mi-Child

OmniCare also has long-standing relationships with key employer and community groups in the service area. The operations improvement plan, referenced elsewhere in this document, addresses the organizational restructuring necessary to support an aggressive marketing program that includes active pursuit of new sales, enriched group service support and the development of niche market opportunities, e.g., self-funded products and TPA services.

In order to increase its commercial enrollment, OmniCare must take several factors into account. First, the focus of the commercial marketing efforts must be concentrated on the mid-sized group market. This group (50-100 eligibles) represents the most fertile market for two reasons. These groups represent the most significant growth market in Michigan as their presence is increasing in SE Michigan. There exists an opportunity for a moderately priced health plan to develop alternative products for these businesses.

Another commercial market factor in OmniCare's favor is the PPO enrollment opportunities. As businesses continue their foray into PPO options, OmniCare TPA can potentially attract attention and sales from this sector. The conversion of the SelectCare PPO business to PPOM opens up market opportunities for a TPA with alternative pricing and servicing options. Though OmniCare is considering a reduction in the size of its Medicaid service area, the commercial market service area may be expanding. Business and population growth in SE Michigan is strongest in Western Wayne, Oakland, Washtenaw, Macomb and Livingston counties.

Detroit's business resurgence has been important to OmniCare. To attract attention and sales from businesses pushing further into the outer metro area, OmniCare must certainly improve its delivery system. The Health Plan must target services and options to the needs of this population, primarily focusing on wellness, women's and pediatric programs. The majority of OmniCare's growth in the next five (5) years must be generated from Wayne and Oakland counties.

Michigan Medicaid managed care enrollment has been steady. The relaxation of the Balanced Budget Act ("BBA") restrictions will create opportunities for OmniCare to re-establish ties with community agencies/programs that will help expand its Medicaid sphere of influence. This will be accomplished through health education and outreach programs.

Additionally, there may be potential new populations available for enrollment under the Health Insurance Flexibility Act ("HIFA") parameters. As government sponsored insurance options expand in the state, OmniCare will likely benefit from enrollment of these beneficiaries. Again, this market position is consistent with OmniCare's business and mission philosophies.

These expanded product development options will be effectively introduced along with several other innovations. The distribution network will be strengthened through the utilization of internal and external sales support. Training and development of the existing staff will be enhanced, including licensing of all marketing sales staff.

The broker and general agent network, already a key factor in OmniCare's sales strategy, will also be reinforced through increased training and tighter recruitment activities. Sales servicing operations will be augmented with aggressive staff training and development. OmniCare's pricing strategies are also being re-evaluated to improve business recruitment and financial returns. Competitive, but cost effective, rating will be standardized.

Promotional programs to support sales functions will be bolstered via a comprehensive campaign that will foster product awareness, introduce new options, promote product differentiation and focus on key partnerships. An aggressive promotional program can critically impact the sales function.

The OmniCare marketing strategies, designed to produce operative stimulus to OmniCare's financial health are as follows:

- Increase membership through enrollment of new business
- Increase membership in existing groups
- Increase market awareness of the new Health Plan options/services
- Develop health education and promotional opportunities with the OmniCare community partners
- Implement a strong professional development program for marketing personnel
- Design programs to encourage more productivity from the general agent/broker contingent
- Renew the Medicaid contract[8]

Information Systems Strategy

A critical area affecting the continued turnaround of OmniCare is its information systems strategy. Attachment E depicts the landscape of OmniCare's current information systems. The software is over 20 years old and does not have the capacity to be effectively updated. In the past, several improperly documented modifications were made to the computer system. As a result, the system lacks the necessary reliability for a successful managed care organization.

OmniCare is in the process of evaluating a new information systems solution. An application service provider ("ASP") arrangement is being considered for several reasons. First, it proves to offer the best solution in terms of capital demands. Considering OmniCare's limited capital, this is an important factor. Second, the agreement can be structured in a manner such that OmniCare can manage as much or as little of the IT operations as it chooses. This allows the organization to put a structure in

[8] OmniCare has received notice from the State of Michigan-Department of Community Health that the Medicaid contract will be extended for a year through September 30, 2003. It is anticipated that negotiations will occur pursuant to the rates to be paid to the contracted MCOs.

place that affords a significant amount of flexibility. Third, in the event that the ASP arrangement does not meet OmniCare's needs long term, the agreement can be terminated, or converted to ownership or another solution implemented.

Attachment F depicts the Information System Landscape-Proposed. The following chart represents the existing and proposed functionality with the respective application where it is known at this time:

OmniCare Information Systems Functionality

Functionality	Currently Available	Proposed Application
HMO Claims Processing[9]	Comtec	QMACS®
HMO Authorization	Comtec	QMACS®
HMO Accounting	N/A	PeopleSoft
PPO Claims Processing	N/A	QMACS®
PPO Authorization	N/A	QMACS®
PPO Accounting	N/A	PeopleSoft
Claims Bundling Software	N/A	Pending
Imaging & Scanning (OCR)-Claims	IPD/RRI	Pending
Claims-EDI-Third-Party	WEB-MD	WEB-MD
EDI-Direct-Claims, Enrollment	N/A	QMACS®
Provider Credentialing Package	N/A	Pending
Data Warehouse	N/A	QMACS®
Reporting tool	N/A	QMACS®
Scanning-Office Documents	N/A	Pending
Office Local Area Network ("LAN")	Windows NT	Pending
Intra-Net	N/A	Pending
Faxing/E-document solution	N/A	Right Fax
IVR System	Softel	Softel
ACD System	Symposium	Pending
Employer/Member Call Tracking	N/A	Pending

HMO processing relates to obtaining a package that meets all of the functional needs of the various user departments. Since the creation of OmniCare TPA, Inc., and its need to process transactions in a PPO environment, the software solution must have PPO functionality. The current software/hardware solution does not have these features thereby hindering OmniCare's growth strategy. The other features targeted in the

[9] Claims processing includes the EDI and OCR capabilities

proposed IT strategy improve OmniCare's capacity to efficiently process and track data and improves OmniCare's administrative operations and service levels.

The proposed solution is a client server product called QMACS®. This package is integrated with the Microsoft© operating system currently in use and is integrated with the local area network ("LAN") software in use at OmniCare: Microsoft Excel, Microsoft Word, Microsoft PowerPoint, Microsoft Exchange and Microsoft Visio.

The existing software had an accounting package that interfaced with the core operating system. Over the years, and as a result of many modifications, the interface was no longer used and is now useless and not worth the effort and cost to reactivate. The QMACS® solution is interfaced with several accounting packages. The desired package with the greatest functionality to meet OmniCare's needs is the PeopleSoft package.

OmniCare does not have a claim bundling software package integrated with its core operating system. This is a major deficiency since significant savings can be realized as a result of implementing the appropriate edits on payments. Normally these packages pay for themselves in approximately 3 months. Therefore, the optimum system must have this functionality or must have a package already integrated. QMACS® comes with a scaled down claims bundling package.

OmniCare is currently utilizing an optical character recognition ("OCR") solution developed by IPD Inc. and RRI, Inc. The product has been effective in managing the inventory of claims to an acceptable level. However, the companies supporting both packages are not motivated to be responsive to OmniCare needs. This results in long delays to make modifications. This solution represents the "front-end" of the EDI solution for volume EDI billers for claims and enrollment changes. Because of the contractor's lack of responsiveness, an alternate solution is being assessed and will be one of the requirements of the ASP arrangement.

The deficiencies in OmniCare's computer systems have also impacted the credentialing process. The current process is completely manual, but an automated solution will be sought. The solution is a product such that when the provider demographic information is loaded onto the computer system, all letters, files etc. are maintained and tracked. QMACS® supports this functionality.

OmniCare needs a data warehouse. These reports are invaluable to meet regulatory reporting requirements as well as useful management tools. With the current platform, the system's limitations and flaws restrict the management team's access to the critical data. When data is extracted, it must be loaded into a spreadsheet and further manipulated before it has any utility. This solution is timely and expensive. The QMACS® package has data management efficacies built in via the warehousing functionality with a report generator included.

OmniCare's LAN services approximately 220 workstations. In addition, capacity exists for the anticipated level of growth. Though the current IT solution has intra-net capability, it has not been developed. Once developed and implemented, this will be a significant addition since several of the enhancements include intra-net functionality. For example, the capacity to effect physician selection, complete benefit and claim inquiries, etc. can be made available to staff. Additionally, providers are granted the ability to status claims via access commonly available through the Internet. Once operational, access to these services will reduce the time it takes to service members and providers, thereby reducing transaction costs, resulting in savings to the Health Plan.

OmniCare installed Softel as its interactive voice response ("IVR") solution. Not only does the system manage eligibility and other demographic inquiries in an automated fashion, it automates the process to receive authorizations for members who want to utilize their refractive benefit. This system is now being evaluated as the vehicle to automate the issuance of all referrals and other forms of authorizations. Once installed, these modifications will generate significant savings via a reduction in the man-hours

required to manually administer these functions. Furthermore, the system will be available 24 hours a day thereby enhancing OmniCare's availability to providers and members.

Significant improvements in other IT areas are underway to improve corporate efficiencies. They include:

- Implementing a scanning solution for other office documents,
- Implementing a fax solution to save cost to deliver notices to providers and employers,
- Implementing a call tracking system to monitor complaints by members and employers,
- Implementing an automated call distribution system ("ACD") system to aid in servicing member and provider calls.

Information Systems Summary

The optimum solution for OmniCare is the ASP approach. It ensures that current releases will be implemented with little cost, it is less expensive to implement and it is less capital intensive.

Upon approval of the Rehabilitation Plan, a detailed implementation IT plan will be developed. The more traditional approach calls for planning to take approximately 3 to 4 months with implementation taking 6 to 12 months. Due to the need to move to a new platform sooner, this process will be expedited with the implementation date being targeted for January 1, 2003.

Debt Restructuring

Two options exist relative to the disposition of OmniCare: liquidation and rehabilitation. Attachment G reflects the liquidation scenario that would result in the un-subordinated creditors receiving approximately $.26 for each dollar of liability.

Liquidation versus Rehabilitation Scenario

Creditor Category	Un-subordinated Creditor Liquidation Rate/ Dollar of Liability	Un-subordinated Creditor Rehabilitation Rate/ Dollar of Liability
Subscribers	$.26	$1.00
Detroit Medical Center	$.26	$.00
Federal Government	$.26	$.55
Physician and Non-Physician Providers	$.26	$.55
Hospitals	$.26	$.35
Pay in Full Providers	$.26	$.25
Pharmacy	$.26	$.25
Primary Care Providers	$.26	$.25
Collection Agencies	$.26	$.00

The liquidation assumptions are fairly conservative and actual payment could be lower.

The second option, rehabilitation, results in the eligible creditors receiving from $.25 to $.55 on each dollar of liability. Excluding the DMC, 48% of the un-subordinated creditor claims would be resolved at $.55, 47% would be resolved at $.35 and 5% would be resolved at $.25. The logic used to determine the reimburse rates will be discussed below.

OmniCare staff has spent considerable time attempting to validate the outstanding liabilities as of the rehabilitation date. Over the last few years, duplicate provider payments were processed, but all of the overpayments were never recovered. These and several other factors have been taken into consideration in validating the amount per provider. Sample letters and a schedule of the providers having received these letters are reflected in Attachment H.

- ***Debt Summary***

A critical component of the rehabilitation of OmniCare Health Plan is a restructuring of the debt, which existed as of July 30, 2001. This debt is primarily made up of medical liabilities owed to providers, capitation withhold potentially due to primary care centers and actual and contingent liabilities to the Federal Government related to OmniCare's participation in the Federal Employees Health Benefit Plan ("FEHBP"). A detailed schedule of medical claims liabilities owed to provider creditors is provided in Attachment I. A summary of all outstanding liabilities is as follows:

Medical claims liabilities	$63,600,000
Capitation withhold	900,000
FEHBP contingent liability	2,600,000
Total un-subordinated liabilities	67,000,000
Surplus notes – UAHC	12,300,000
Surplus notes – DMC	5,000,000
Total subordinated liabilities	17,300,000
Total Liabilities	$84,300,000

- ***Debt Reduction Strategy***

The Rehabilitation Plan calls for a cash payout to creditors of $17.5 million dollars, conversion of approximately $24.3 million in debt to surplus notes and writes offs of approximately $25.3 million. Upon restructure of the debt, OmniCare's net worth improves by approximately $47.9 million dollars to a negative $6.4 million dollars. Attachment J provides a summary of the transaction. Once the Rehabilitation Plan is approved, it is projected that the cash payout can be completed within sixty (60) days.

Medical Liabilities-Provider creditors

In accordance with the Rehabilitation Order, OmniCare immediately reprogrammed the claims payment system to only allow payment of claims with dates of service subsequent to July 30, 2001. Claims with dates of service prior to July 31, 2001 continued to be processed and adjudicated as a liability within the system, however the amounts due remained in accounts payable and were not disbursed. This allowed for an accounting of the amounts actually owed as of July 30, 2001 for a seven month run-out period (through February 2002). In December 2001, a detailed confirmation of claims recorded as due and payable within the claims system was sent to each provider creditor with a request to review and validate the liability to their accounting records and to respond with any alleged discrepancies. During January and February 2002, many providers responded to these requests with the specific claims to support their challenges. These claims were adjudicated expeditiously to determine ultimate liability for proper reflection in the rehabilitation claims pool as reflected herein as of March 5, 2002. A summary reflecting the results of the debt confirmation and reconciliation efforts is included in Attachment K.

In the normal course of business and prior to the rehabilitation order, OmniCare attempted to reconcile provider payments and settle with certain providers on their outstanding liabilities. This process was not completed when the Health Plan was placed in rehabilitation. To develop a fair and equitable liability framework, liabilities and cash were restated to add back payments made for the one-year period prior to the rehabilitation order. Payments were then redistributed to providers on a pro-rata basis to determine a restated “look back” liability upon which to apply the specific cash payment percentages. There were two constraints employed in this analysis. The first was to redistribute negatives thereby not requiring previous payments to be recovered in the rehabilitation scenario. The second was to limit a providers calculated payment on the restated “look back” liability to their actual outstanding liability. This “look-back” approach is consistent with the tenets of MCL 500.8130 pertaining to liquidations. The approach was used here in an effort to bring all creditors to an equitable starting point in the rehabilitation.

Medical claim liabilities were stratified into eight classes. The debt restructuring approach employed under this Rehabilitation Plan calls for the payment of creditors at varying percentages of amounts due for each class. These percentages and payment terms were derived giving consideration to such factors as size of provider's outstanding debt, favor of provider's contractual (or non-contractual) payment arrangement, provider's perceived ability to discount the liability and the Health Plan's ability to pay. These categories, the proposed reimbursement and the rationale for the proposed reimbursement under this debt-restructuring plan are as follows:

- **Subscribers**-This class contains OmniCare members who in response to collection efforts by providers have paid medical claims that should have been paid by OmniCare. These members will receive 100% of the amounts they paid on OmniCare's behalf. The total payments to this class of creditors are $10,557.

- **The Detroit Medical Center (Individually Large Provider Creditor)**-This class represents liabilities to the Detroit Medical Center hospitals. The Detroit Medical Center (DMC) is a critical component of this Rehabilitation Plan. Outstanding liabilities to DMC represent 38% of total medical claims liabilities. Under the Rehabilitation Plan, the DMC will receive no cash for outstanding medical liabilities. Their liabilities will be converted to surplus notes. These notes will be convertible into non-voting preferred stock upon OmniCare's conversion to for-profit status. Given the size of the liabilities to DMC, restructuring their debt into equity instruments creates more cash available to other creditors. Additionally, the proximity and interdependence between the organizations (OmniCare and DMC) with respect to enrolled populations and delivery systems, make it a natural fit for a closer, more formalized long-term relationship. Negotiations are underway to finalize the terms and conditions of the debt/equity instruments. The goal and intent of the parties is to finalize and execute the definitive agreement prior to the April 25th hearing on the petition for

rehabilitation as failure to close would have negative implications on the cash available to other creditors.

- **Physician and Non-Physician Medical Providers**-This class of creditors includes physician (excluding capitated primary care physicians) and other non-physician providers of medical services to OmniCare members. Non-physician providers include chiropractors, dentists, home health agencies, laboratories, physical therapists, medical suppliers and optometrists. This class consists of 3,877 creditors with an average claim of $4,590. The claims of this class of creditors represent 28% of total medical claims liabilities. This class of creditors will be paid 55% of the contractual value of their claims. This higher percentage is deemed appropriate given the larger number of smaller creditors, which primarily deliver personal medical services.

- **Hospital Facility Providers**-This class of creditors consists of hospitals and hospital systems and includes 435 creditors with an average claim of $46,028. The claims of this class of creditors represent 20.3% of total medical claims liabilities. This class of creditors will be paid 35% of the contractual value of their claims.

- **Pay In Full Providers**-This class of creditors contains physician, non-physician, hospital and other facility providers who have not agreed to participate in OmniCare's provider panel and accept the Health Plan's fee schedule. The liabilities for providers in this category are based upon 100% of the provider's billed charges for covered services. This class consists of 384 creditors with an average claim of $3,291. The claims of this class represent 2% of total medical claims liabilities. This class of providers will be paid at 25% of the contractual value of their claims. This lower percentage is justified in relation to the reimbursement for other provider's whose liabilities are already contractually discounted to approximately 40% of charges on average.

- **Pharmacies-**The creditors in this class are pharmacies and pharmaceutical companies. This class consists of 3 creditors, one of which represents 99% of the $35,993 outstanding amount. This class of creditors will be paid at 25% of the contractual value of their claims. Since pharmacy claims are processed on-line with minimal payment lag, this lower percentage is justified in relation to the reimbursement for other provider's subject to a lag in payment, thereby increasing their exposure to non-payment.

- **Primary Care Centers**-This class of creditors consists of the primary care physicians who provided medical services to OmniCare members and who receive prepayment for their services on a capitated basis. This class consists of 97 creditors with an average amount due of $743. The claims of this class of creditors represent .1% of total medical liabilities. This class of creditors will be paid at 25% of the contractual value of their claims. Payment at 25% is justified because the capitated payments exposed them to a lower risk of nonpayment and shorter lag between payment and provision of services. Thus, as a group this class of creditors experienced smaller losses than other provider creditors.

- **Collection Agencies-** The claims asserted by collection agencies on behalf of medical providers are addressed by inclusion in one of the previously described class of providers. The claims underlying the collection efforts will be paid or discharged according to the classification of the provider creditor. Accordingly, no moneys will be paid to collection agencies.

Capitation Withhold

Under its contracts with primary care physicians (PCP's), OmniCare pays for the delivery of primary care services through monthly capitation payments. Capitation payments to providers are subject to a 10% withhold of the total capitation payment. From the

providers perspective this withhold fund is at risk based upon their referral experience measured against a risk pool funded by the Health Plan. The risk pools are funded by a contractually determined amount and the provider's referral services are charged against the pool. Each year the referral risk pool is evaluated for surplus or deficiency for each primary care center. In the event a primary care center's referral pool is in a surplus, the Health Plans liability to that provider is their withhold plus a bonus of 100% of the surplus (which is limited to 50% of the providers withhold). In the event of a deficiency, the deficit is charged against the withhold fund. If the deficit is larger than the provider's withhold fund, the entire withhold is retained by the Health Plan to offset the deficiency. If the withhold fund is larger, the deficit is retained from the withhold fund and the remainder is the Health Plan's liability to that primary care center. A summary of the referral pool activity and resulting withhold/surplus liability as of July 30, 2001 is included in Attachment L. Under the Rehabilitation Plan, amounts due totaling $896,636 will be paid at 25% of the contractual value. This is consistent with the medical claims liability reimbursement percentage and justification for primary care centers explained above.

Federal Government-Employer Group

OmniCare has had a contract with the FEHBP since its approval for participation in 1979. Under this employer group contract, Plans are required by law to offer the FEHBP premium rates that are at or lower than the rates offered to the two groups closest in size to the FEHBP (SSSG's), adjusted for benefit differences. The development of rates for the FEHBP and the SSSG's are subject to review and audit by the United States Office of Personnel Management (OPM) in order to ascertain that the rates adhere to the legal criteria. Pursuant to a settlement agreement with the OPM for an audit of the rate development for the years 1988-1992, OmniCare has an outstanding balance of $231,566 due to the Federal government. Additionally, OmniCare has recently undergone an audit of the years 1996-2000 for which OmniCare has recorded a contingent liability of $2.3 million for potential amounts due to OPM related to the rate development of those years. As the FEHBP is OmniCare's 2nd largest commercial employer group and critical to the

growth and membership projections on which the rehabilitation plan is based, it is proposed that OmniCare pay the Federal Government for amounts due and determined to be due under the FEHBP contract for dates on or prior to 7/30/01 at $.55 per dollar owed through reduction in future premiums due.

Surplus Notes

As of July 30, 2001, OmniCare had surplus notes outstanding in the amount of $17.3 million. These surplus notes are made up of $12.3 million in surplus notes from United American Health Care Corporation and $5 million from the Detroit Medical Center. Since surplus notes are subordinate to all other creditors who are receiving less than 100% on the dollar as proposed hereunder, it is proposed and justifiable to reimburse surplus notes at 0%. Since DMC's notes were created out of pre-rehabilitation medical claims liabilities and DMC is receiving no cash for outstanding un-subordinated medical claims liabilities availing more cash to other creditors, it is proposed under the rehabilitation plan to roll their existing surplus notes into the new surplus notes to be issued pursuant to this plan.

Administrative Creditors

There are no administrative vendors listed as creditors. Under the management agreement and in exchange for management fees paid, United American Health Care Corporation is responsible for payments due to trade vendors. The only exceptions are payments to Board of Trustee members for meeting attendance for which no amounts are due as of the date of the rehabilitation order.

Pending Lawsuits

OmniCare has five (5) open litigation files. They are as follows:

Outstanding Legal Cases

Claimant	Basis	Claim Amount
Total Family Health Services, PC vs. Michigan HMO Plans d/b/a/OmniCare Health Plan	Reimbursement for Legal Fees	$130,000
Henry Ford Hospital vs. Edna Scott vs. Prudential Ins and OmniCare	COB Case Auto Insurance	$8,420.75
Nadia Solomon-Searcy vs. Auto Owners Insurance Company and OmniCare Health Plan	COB Case Auto Insurance	Approximately $25,000
Wakeker Blinks vs. Michigan HMO Plans d/b/a/OmniCare Health Plan	COB Case	$39,568.85
Botsford General Hospital vs. OmniCare Health Plan	Reimbursement for claims	$1.5million

The Total Family Health Services, PC vs. Michigan HMO Plans d/b/a/OmniCare Health case represents an attempt on the part of the plaintiff to recover legal fees. Total Family Health Services (TFHC") initiated a lawsuit against OmniCare. The case went to arbitration and TFHC was awarded $305,968.97. TFHC filed an appeal to be reimbursed $130,000 in legal fees. Under this Rehabilitation Plan it is proposed that no additional payments be made.

The next three cases are COB cases in which issues are open relative to the liable party: OmniCare Health Plan or the other insurer. In all of these cases, the issue relates to the payment of medical claims that are addressed in the aforementioned classes of medical claims liabilities. It is therefore proposed that no additional payments be made.

The case of Botsford Hospital vs. OmniCare is a reimbursement issue. Botsford Hospital's claims are contained in the aforementioned classes of medical claims liabilities. It is therefore proposed that no additional payments be made.

Financials

- **Administrative Cost**

UAHC holds the lease for office space. Since the management agreement with UAHC is being terminated, OmniCare must either negotiate a lease in the current facility or seek other office facilities.

Equis Corp. was contracted to assist in the assessment of office space in the City of Detroit, Michigan. An alternative location was identified and the lease cost compared to the current Brewery Park facility will generate a savings of approximately $1.7 million dollars over a five (5) year period. Therefore, continuing to house the operation in the Brewery Park facility does not seem to be a viable solution; upon approval of the Rehabilitation Plan, OmniCare will begin the relocation process.

- **December 31, 2000 Financials**

KPMG audited the financials of OmniCare as of December 31, 2000. A copy of this report is included as Attachment M. Their report indicated that OmniCare's records were not auditable. In addition, they doubted the ability of OmniCare to continue in business. Therefore, they expressed no opinion on the financial statements.

OmniCare reported a loss of approximately $13.0 million in 2000. Approximately $13.0 million in surplus notes were issued during the year. Coupled with the proposed acquisition, it was anticipated that the transaction would allow OmniCare to meet the State reserve requirements.

- **July 31, 2001 Balance Sheet**

A snapshot was taken of OmniCare' financial performance as of the rehabilitation date, July 31, 2001. A balance sheet is included as Attachment N. The purpose was to establish the benchmark to measure future financial performance. Early in the rehabilitation process, December 1,2001 was established as the date by which a liquidation or rehabilitation recommendation would be forthcoming. The starting point was the rehabilitation date.

When the books were closed, it was determined that medical cost had been significantly understated. Once the analysis was completed, approximately $25 million dollars in medical cost related to prior years was identified. Since the books for these years were closed, the cost was recorded in the current year. As a result, OmniCare's deficit as of July 31, 2001 was approximately $57 million.

- **Financial performance August-2001 through December-2001**

OmniCare's financial performance for the 5 months of the 2001 rehabilitation period is reflected in Attachment O. For the five-month period of time, OmniCare generated a surplus of approximately $3 million after proper classification and restatement of pre and post rehabilitation operations. Considering the monthly losses pre-rehabilitation, this is a significant turnaround in that this performance is without 100% of the benefits of the planned operational improvements.

- **2002 Budget**

The 2002 Budget was developed with conservative membership growth and financial targets. Medicaid membership is flat due to a lack of ability to grow due to the number of approved contractors servicing the same counties as OmniCare. Additionally, the

budget reflects the departure of OmniCare in servicing Oakland County. As a result, OmniCare will limit its Medicaid participation to Wayne County.

Minimal growth is projected for the commercial membership. Due to the negative perceptions and poor financial performance of the Health Plan for the last four (4) years, it will take time to attract a significant amount of new business.

During the latter part of 2001, OmniCare experienced a surplus in its operations. It is projected that similar performance will occur for 2002. Medicaid rates have been held flat because of the many uncertainties associated with Medicaid funding. The issues are not at a point that they can be quantified in the budget.

Commercial rate increases are projected at approximately 16%. Based on an assessment of the January and February 2002 premium billings, there is a high degree of confidence that the premium projections for the remainder of the year will be attained.

A summary of the 2002 budget is included in Attachment P.

- **5 Yr Projections**

OmniCare is not in compliance with the reserve requirements of the State of Michigan-OFIS. Coupled with a strategy to convert to for profit, a 5-year projection was completed to assess compliance and place a value on the company. The 5-year projections are reflected in Attachment Q.

The growth and financial performance assumptions were conservative. Medicaid membership growth continues to be flat. Commercial membership growth shows conservative estimates of 10% to 15%. Although the percentage increases are fairly aggressive, the net increase in members is fairly small given the 22,000 base members.

OmniCare commercial rates have tended to be below market. The projections utilize assumptions to generate rates that are competitive with health plans in southeastern Michigan and more importantly, to cover the cost of providing care. Relative to Medicaid rates, though 2002 is flat, it is projected that there will be a slight increase in the 2003. Subsequently, the rates vary based on best estimates of what will occur based on a change in administration in the State of Michigan and provider pressures to increase rates.

The medical loss ratios ("MLR") continue to be high based on the membership served and current medical experience. The Medicaid MLR is above 90% and it is projected that it will remain at this level for the purpose of the projections. The commercial MLR is lower, but it is still above what is projected for a mature HMO due to the reduction in membership and the probability of servicing a population that requires more service.

Administrative expenses remain at approximately 10% of revenue. A new computer system will be installed in 2003. Though there will be efficiency gains in administrative functions, these gains have not been factored in thereby yielding conservative projections.

Based on the aforementioned assumptions, the projected surplus is approximately 2% annually.

The following represents the assumptions utilized in the projections:

OmniCare Assumptions

Category	2002	2003	2004	2005	2006
Membership- Com'l	22,738	26,438	29,081	31,990	35,189
Membership-Medicaid	63,477	63,477	63,477	64,112	64,753
Revenue- Com'l ($1,000)	$45,975	$57,751	$68,608	$81,507	$96,830
Revenue-Medicaid ($1,000)	$133,350	$137,351	$141,471	$148,601	$156,091
Admin. Cost ($1,000)	$18,036	$19,217	$20,575	$22,080	$26,664
Surplus ($1,000)	$4,355	$4,472	$4,173	$5,026	$6,411

Implementation Schedule

This *restoration* period will consist of disbursement of the provider payments based on the approved Rehabilitation Plan, converting the organization to for profit, seating of the Board of Directors, restructuring the non-cash debt to equity, converting the organization to a director company, relocating the corporate offices, converting the staff to OmniCare employees, planning and implementing the information systems strategies and continuing to focus on improving the existing organization.

At a reasonable point in time, when the organization stabilizes, and has shown continued improvement and that it is meeting its financial and membership targets, the Ingham County Court will be petitioned to remove the rehabilitation status. The following represents the projected timeframes:

Implementation Schedule[10]

Task	Completion Date
• 90-Day termination notice to UAHC	June 1, 2002
• Relocation of corporate offices	September 1, 2002
• Plan system strategy	May 1, 2002
• Convert Personnel to OmniCare	September 1, 2002
• Install Systems Solution	January 1, 2003
• Disbursement of cash: Rehabilitation Plan	June 1, 2002
• Conversion to for profit	September 1, 2002
• Installation of a Board of Directors	November 1, 2002

The current HMO reserve requirements stipulating an HMO to a minimum $500,000 in positive net worth, has been repealed. The revised requirements that go into effect

[10] Note: The above assumes the Rehabilitation Plan is approved as submitted prior to the end of April 2002.

December 31, 2003 require that the HMO must maintain a minimum net worth that is the greater of 4% of annualized revenue or $1.5 million. Based on OmniCare's 5-year projections, the minimum net worth requirement is $9.2 million.

Recommendations

Therefore, the Ingham County Court is being petitioned for the following:

- Approve the Rehabilitation Plan as submitted.
- Stipulate that the reimbursement rate for Medicaid recipients be at the Medicaid rates as periodically modified by the State of Michigan.
- Stipulate that the injunctions in the original rehabilitation court order remain in effect during the duration of the rehabilitation status